		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0005397

Facility Name: La Moine Christian Nursing Home

Address: 145 South Chamberlain - Box 770 (Number) Roseville (City) 61473-0770 (Zip Code)

County: Warren

Telephone Number: (309) 462-2134 **Fax #** ( )

IDPA ID Number: 37-08415692003

Date of Initial License for Current Owners: 09/01/70

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(C)3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: William O. Buskirk **Telephone Number:** (217) 525-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1, 1999 to June 30, 2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Mark Havrilka
(Title) Chief Financial Officer

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) William O. Buskirk, CPA
(Firm Name & Address) Eck, Schafer & Punke, LLP 600 East Adams Springfield IL 62701-1624
(Telephone) (217) 525-1111 Fax # (217) 525-1120

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,234	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,234	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,569	3,645		15,214	8
9	SNF/PED					9
10	ICF	7,035	6,384		13,419	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,604	10,029		28,633	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.02%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 09/70

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/00 Fiscal Year: 06/30/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	148,911	13,458	6,480	168,849		168,849		168,849			1
2	Food Purchase		138,861		138,861		138,861	(70)	138,791			2
3	Housekeeping	71,117	13,412		84,529		84,529		84,529			3
4	Laundry	62,516	13,549		76,065		76,065		76,065			4
5	Heat and Other Utilities			71,798	71,798		71,798	(4,264)	67,534			5
6	Maintenance	32,825	11,644	17,685	62,154		62,154	4,077	66,231			6
7	Other (specify):*											7
8	**TOTAL General Services**	315,369	190,924	95,963	602,256		602,256	(257)	601,999			8
	B. Health Care and Programs											
9	Medical Director			500	500		500		500			9
10	Nursing and Medical Records	924,173	46,296	6,600	977,069		977,069		977,069			10
10a	Therapy			13,152	13,152		13,152		13,152			10a
11	Activities	29,330			29,330		29,330		29,330			11
12	Social Services	61,789	991	2,446	65,226		65,226		65,226			12
13	Nurse Aide Training											13
14	Program Transportation			1,246	1,246		1,246		1,246			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,015,292	47,287	23,944	1,086,523		1,086,523		1,086,523			16
	C. General Administration											
17	Administrative	48,862		110,741	159,603		159,603	(88,016)	71,587			17
18	Directors Fees											18
19	Professional Services							11,582	11,582			19
20	Dues, Fees, Subscriptions & Promotions			11,042	11,042		11,042	(5,505)	5,537			20
21	Clerical & General Office Expenses	53,533	5,151	17,354	76,038		76,038	11,500	87,538			21
22	Employee Benefits & Payroll Taxes			201,640	201,640		201,640	3,887	205,527			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,978	5,978		5,978	1,559	7,537			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			11,259	11,259		11,259	856	12,115			26
27	Other (specify):*											27
28	**TOTAL General Administration**	102,395	5,151	358,014	465,560		465,560	(64,137)	401,423			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,433,056	243,362	477,921	2,154,339		2,154,339	(64,394)	2,089,945			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number La Moine Christian Nursing Home #0005397 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			101,397	101,397		101,397	8,250	109,647			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			1,092	1,092		1,092		1,092			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			725	725		725		725			35
36	Other (specify):*											36
37	**TOTAL Ownership**			103,214	103,214		103,214	8,250	111,464			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops	14,680	555		15,235		15,235		15,235			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,352	54,352		54,352		54,352			42
43	Other (specify):* Maint & Supp Clinic			860	860		860		860			43
44	**TOTAL Special Cost Centers**	14,680	555	55,212	70,447		70,447		70,447			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,447,736	243,917	636,347	2,328,000		2,328,000	(56,144)	2,271,856			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(70)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,685)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,570	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	120	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(3,600)	21		24
25	Fund Raising, Advertising and Promotional	(6,116)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(89)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (10,870)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(45,274)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (45,274)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (56,144)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

La Moine Christian Nursing Home

ID# 0005397

Report Period Beginning: July 1, 1999

Ending: June 30, 2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Machine	$ (137)	21	1
2	Activity Revenue	48	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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43				43
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67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(89)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(70)	0	0	0	0	0	0	0	0	0	0	(70)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,685)	421	0	0	0	0	0	0	0	0	0	(4,264)	5
6	Maintenance	0	4,077	0	0	0	0	0	0	0	0	0	4,077	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,755)	4,498	0	0	0	0	0	0	0	0	0	(257)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(88,016)	0	0	0	0	0	0	0	0	0	(88,016)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	11,582	0	0	0	0	0	0	0	0	0	11,582	19
20	Fees, Subscriptions & Promotions	(6,116)	611	0	0	0	0	0	0	0	0	0	(5,505)	20
21	Clerical & General Office Expenses	(3,569)	15,069	0	0	0	0	0	0	0	0	0	11,500	21
22	Employee Benefits & Payroll Taxes	0	3,887	0	0	0	0	0	0	0	0	0	3,887	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,559	0	0	0	0	0	0	0	0	0	1,559	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	856	0	0	0	0	0	0	0	0	0	856	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(9,685)	(54,452)	0	0	0	0	0	0	0	0	0	(64,137)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(14,440)	(49,954)	0	0	0	0	0	0	0	0	0	(64,394)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 **Report Period Beginning:** July 1, 1999 **Ending:** June 30, 2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	3,570	4,680	0	0	0	0	0	0	0	0	0	8,250	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	3,570	4,680	0	0	0	0	0	0	0	0	0	8,250	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(10,870)	(45,274)	0	0	0	0	0	0	0	0	0	(56,144)	45

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	UTILITIES	$	Christian Homes Inc	100.00%	$ 421	$ 421	1
2	V	6	MAINTENANCE				4,077	4,077	2
3	V	17	ADMINISTRATIVE	109,332			21,316	(88,016)	3
4	V	18	DIRECTORS						4
5	V	19	PROFESSIONAL SERVICES				11,582	11,582	5
6	V	20	FEES/SUBSCRIPTIONS/PROMO				611	611	6
7	V	21	CLERICAL				15,069	15,069	7
8	V	22	EMPLOYEE BENEFITS	3,000			6,887	3,887	8
9	V	23	INSERVICE						9
10	V	24	TRAVEL				1,559	1,559	10
11	V	26	INSURANCE				856	856	11
12	V	30	DEPRECIATION				4,680	4,680	12
13	V								13
14	Total			$ 112,332			$ 67,058	$ * (45,274)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This worksheet is not applicable								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 1999 Ending: ne 30, 2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		This worksheet is not applicable				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	This worksheet not applicable						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$	#VALUE!	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	#VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,150 B. General Construction Type: Exterior Steel Frame Masonry Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: None
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	130,680	1968	$ 10,992	1
2	Home Office			4,014	2
3	TOTALS	130,680		$ 15,006	3

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	62		1971	1971	$ 671,598	$ 16,565	40	$ 16,790	$ 225	$ 476,358	4
5	37		1975	1975	545,572	12,074	36	15,154	3,080	307,311	5
6			1971	1971	118,518		20				6
7			1975	1975	96,278		16				7
8	Home Office				28,643	936		936		12,435	8
	Improvement Type**										
9	Land Improvements			1974	8,378		20			8,378	9
10	Building Improvements			1977	2,335	52	33	71	19	1,157	10
11	Windows			1980	8,654	192	45	192		3,886	11
12	Windows			1980	8,415	191	44	191		3,725	12
13	Remodeling			1981	341	8	34	10	2	152	13
14	Remodeling			1981	2,643	60	34	60		1,144	14
15	Heating Systems			1982	50,515	2,526	20	2,526		45,047	15
16	Garage			1982	9,457	378	25	378		6,836	16
17	Water Meter			1982	878	44	20	44		774	17
18	Furnace			1983	5,889	294	20	294		4,998	18
19	Building Improvements			1983	5,309	123	33	160	37	2,132	19
20	Front Door Exchange			1984	1,142	27	35	32	5	439	20
21	Bagley House			1984	15,802		10			15,802	21
22	Land Improvements			1986	500		10			500	22
23	Office Remodel			1986	13,549	339	25	541	202	4,718	23
24	Ventilating Fan			1987	463	3	10	3		463	24
25	Storm Sewer			1987	16,568	828	20	828		10,695	25
26	Drainage Survey			1987	453	23	20	23		301	26
27	Lighting Fixture			1987	480		10			480	27
28	Land Improvements			1987	477	24	20	24		310	28
29	Angle Frame			1987	1,015	51	20	51		659	29
30	Storm Sewer			1987	1,247	62	20	62		806	30
31	Floor Tile			1988	2,089		5			2,089	31
32	New Kitchen A/C Pump			1988	1,556	104	15	104		1,248	32
33	Door Monitor			1989	1,170	78	15	78		897	33
34	Remodeling			1989	2,901	145	20	145		1,655	34
35	Construction in Progress			1989	6,510		20				35
36	TOTAL (lines 4 thru 35)				$ 1,629,345	$ 35,127		$ 38,697	$ 3,570	$ 915,395	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Door Monitor			1989	2,218	17	10	17		2,218	9
10	E W SGL Door Monitor			1989	1,057	70	15	70		764	10
11	Fire Alarm System			1990	16,365	818	20	818		8,521	11
12	Conventional Oven			1991	2,510	167	15	167		1,656	12
13	Light Fixtures			1991	395	40	10	40		393	13
14	Carpeting			1991	346	1	5	1		346	14
15	Trees & Schrubs			1991	1,315	66	20	66		605	15
16	Compressor			1992	1,126	113	10	113		989	16
17	Phone System			1992	623	62	10	62		532	17
18	Cubicle Track			1992	2,888	289	10	289		2,457	18
19	Hot Water System			1993	13,270	885	15	885		6,490	19
20	Remodeling			1993	5,233		5			5,233	20
21	Yard Barn			1994	500		7			500	21
22	Wallcoverings/carpet			1994	3,744		5			3,744	22
23	TV Antennae			1994	4,351	435	10	435		2,652	23
24	Flourscent Light Fixtures			1994	608	8	5	8		608	24
25	Wallcoverings			1995	1,445	144	5	144		1,445	25
26	Remodel 4 rooms			1995	2,862	383	5	383		2,862	26
27	Wallpaper			1995	600	100	5	100		600	27
28	Asphalt Parking Light			1995	15,426	1,543	10	1,543		7,844	28
29	Flourscent Light Fixtures			1995	908	91	10	91		440	29
30	Bus Barn-E Railroad			1995		53	20	53			30
31	Egress Locking System			1995	3,252	650	5	650		2,979	31
32	Floorcoverings			1995	3,856	771	5	771		3,470	32
33	Wallpaper			1995	3,821	764	5	764		3,438	33
34	Roof			1996	168,868	11,258	15	11,258		45,032	34
35	Roof Exhaustor			1996	750	150	5	150		587	35
36	TOTAL (lines 4 thru 35)				$ 258,337	$ 18,878		$ 18,878	$	$ 106,405	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	3 foot Bathroom fixtures			1996	935	187	5	187		732	9
10	Wallcoverings			1996	874	175	5	175		671	10
11	Vinyl-S Wing Wallway			1996	3,012	602	5	602		2,258	11
12	Wallcoverings - 5 rooms			1996	2,946	589	5	589		2,111	12
13	Sewer/Garbage Disposal			1996	3,058	612	5	612		2,193	13
14	Ceiling Tile Laundry			1997	1,237	124	10	124		362	14
15	Water Softner System			1997	10,033	2,007	5	2,007		5,686	15
16	Energy Management System			1997	14,830	1,483	10	1,483		3,955	16
17	Replumb end of N H			1997	14,103	1,410	10	1,410		3,642	17
18	Wallcoverings			1997	985	197	5	197		509	18
19	Dining Room Windows			1997	6,533	653	10	653		1,687	19
20	Remodel Bathroom			1997	2,229	446	5	446		1,152	20
21	Remodel Office			1998	1,696	339	5	339		848	21
22	Wallpaper Restroom			1998	3,003	601	5	601		1,402	22
23	Overhead Door			1998	1,258	126	10	126		284	23
24	Carpet-Lobby			1999	2,566	513	5	513		898	24
25	Wallpaper-Hallways			1999	14,431	2,886	5	2,886		4,569	25
26	Motherboards-Fire Alarm			1999	1,385	277	5	277		416	26
27	Wallpaper-Restrooms			1999	5,733	1,147	5	1,147		1,147	27
28	Door Locking System			1999	9,490	1,898	5	1,898		2,214	28
29	Windows-Dining Room			1999	7,640	509	15	509		636	29
30	Landscaping			2000	805	7	10	7		7	30
31	Parking Lot Resurface			2000	3,500	973	3	973		973	31
32	Sign for Front of Building			2000	580	5	10	5		5	32
33	Serving Lamps			2000	1,470	270	5	270		270	33
34	Entrance Canopy w/Sidewalk			2000	3,577	328	10	328		328	34
35	Wallpaper			2000	1,164	136	5	136		136	35
36	TOTAL (lines 4 thru 35)				$ 119,073	$ 18,500		$ 18,500	$	$ 39,091	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Wallpaper			2000	5,430	272	5	272		272	9
10	Light Fixtures			2000	1,039	9	10	9		9	10
11	Seagull Fixture			2000	5,631	47	10	47		47	11
12	Deluxe Composite Stool			2000	1,404	12	10	12		12	12
13	Sink (North Port-R Med)			2000	908	76	10	76		76	13
14	Seagull Fixture (8)			2000	856	7	10	7		7	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 15,268	$ 423		$ 423	$	$ 423	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 145,241	$ 21,754	$ 21,754	$		$ 61,304	37
38	Current Year Purchases	24,058	2,063	2,063			2,063	38
39	Fully Depreciated Assets	173,618					173,618	39
40	Home Office	25,001	2,580	2,580			20,328	40
41	TOTALS	$ 367,918	$ 26,397	$ 26,397	$		$ 257,313	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Patient Transportation	1979 GMC Van	1979	$ 10,311	$	$	$	5	$ 10,311	42
43	Patient Transportation	1994 Ford Bus	1994	44,700	5,588	5,588		8	33,995	43
44										44
45	Home Office Allocation			5,444	1,164	1,164			1,678	45
46	TOTALS			$ 60,455	$ 6,752	$ 6,752	$		$ 45,984	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 2,465,402	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 106,077	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 109,647	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 3,570	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,364,611	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Land	$ 85,051	$	$	52
53	Clinic Land	9,250			53
54	House	15,802		15,802	54
55					55
56					56
57	TOTALS	$ 110,103	$	$ 15,802	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [x]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$ 1,752	$ 876	$	$ 2,628
2	Books and Supplies	248	124		372
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		100		100
9	TOTALS	$ 2,000	$ 1,100	$	$ 3,100
10	SUM OF line 9, col. 1 and 2 (e)	$ 3,100			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	6
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	4
2. From other facilities (f)	
TOTAL TRAINED	6

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$ Not Applicable		$	$		$ #VALUE!	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$ #VALUE!	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of June 30, 2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 121,004	$	1
2	Cash-Patient Deposits	10,178		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 13,600)	112,838		3
4	Supply Inventory (priced at FIFO)	20,183		4
5	Short-Term Investments	824,910		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Interest Receivable	3,521		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,092,634	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	105,292		13
14	Buildings, at Historical Cost	1,935,248		14
15	Leasehold Improvements, at Historical Cost	51,620		15
16	Equipment, at Historical Cost	397,927		16
17	Accumulated Depreciation (book methods)	(1,330,169)		17
18	Deferred Charges	12,840		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	455,774		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP	6,510		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,635,043	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,727,677	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 30,718	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,178		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	81,487		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	953		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 123,336	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 123,336	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,604,341	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,727,677	$	48

***(See instructions.)**

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,597,721	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,597,721	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	6,620	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 6,620	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,604,341	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,807,080	1
2	Discounts and Allowances for all Levels	(636,958)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,170,122	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education	1,645	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	89	12
13	Barber and Beauty Care	16,277	13
14	Non-Patient Meals	70	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 18,081	23
	D. Non-Operating Revenue		
24	Contributions	77,773	24
25	Interest and Other Investment Income***	83,832	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 161,605	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Miscellaneous**	309	28
28a	**Gains/Losses, Unrealized Gains/Losses**	(15,498)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (15,188)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,334,620	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	602,256	31
32	Health Care	1,086,523	32
33	General Administration	465,560	33
	B. Capital Expense		
34	Ownership	103,214	34
	C. Ancillary Expense		
35	Special Cost Centers	15,235	35
36	Provider Participation Fee	54,352	36
	D. Other Expenses (specify):		
37	**Maintenance Clinic**	860	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,328,000	40
41	**Income before Income Taxes (line 30 minus line 40)****	6,620	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 6,620	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,738	1,908	$ 34,315	$ 17.98	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,229	10,133	163,185	16.10	3
4	Licensed Practical Nurses	15,972	17,528	215,807	12.31	4
5	Nurse Aides & Orderlies	48,051	52,762	471,319	8.93	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,775	1,949	29,330	15.05	9
10	Activity Assistants					10
11	Social Service Workers	6,334	6,955	61,789	8.88	11
12	Dietician					12
13	Food Service Supervisor	2,288	2,512	23,291	9.27	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,334	16,837	125,620	7.46	15
16	Dishwashers					16
17	Maintenance Workers	2,705	2,970	32,825	11.05	17
18	Housekeepers	7,916	8,692	71,117	8.18	18
19	Laundry	6,831	7,500	62,516	8.34	19
20	Administrator	1,913	2,100	48,862	23.27	20
21	Assistant Administrator					21
22	Other Administrative	815	894	7,854	8.79	22
23	Office Manager	1,741	1,910	23,107	12.10	23
24	Clerical	2,624	2,881	22,572	7.83	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	3,505	3,848	39,547	10.28	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Beauty Shop	1,232	1,352	14,680	10.86	33
34	TOTAL (lines 1 - 33)	130,003	142,731	$ 1,447,736 *	$ 10.14	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	20	500		36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	72	3,119		39
40	Physical Therapy Consultant	83	7,407		40
41	Occupational Therapy Consultant	12	2,551		41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	37	3,193		43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	224	$ 16,770		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
James Bray	Administrator	0	$ 23,118
Wirt Thompson	Administrator	0	25,744
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 48,862

B. Administrative - Other

Description	Amount
Management Fee	$ 109,332
Other Administrative Expense	1,409
TOTAL (agree to Schedule V, line 17, col. 3)	$ 110,741
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
n/a		$
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 39,624
Unemployment Compensation Insurance	3,000
FICA Taxes	106,813
Employee Health Insurance	38,610
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Expense	8,641
Employee Physicals	1,465
Worker's Comp Medical Expense	3,487
Home Office Allocation	6,887
Related Party Adjustment	(3,000)
TOTAL (agree to Schedule V, line 22, col.8)	$ 205,527

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Software Support	890
Fees and License	401
Subscription	27
Dues	3,608
Home Office Allocation	611
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,537

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 20
In-State Travel	2,058
Seminar Expense	2,774
Miscellaneous	1,126
Home Office Allocation	1,559
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,537

**See instructions.

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 1999 Ending: June 30, 2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number La Moine Christian Nursing Home # 0005397 Report Period Beginning: July 1, 1999 Ending: June 30, 200

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **INHAA/IAHA - $3,568**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,794** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **54,352**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **70**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: **Eck, Schafer & Punke LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Will be provided upon completion.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.